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Medical Times

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The American Profession

Pulmonary Tuberculosis

Research in Medical Schools

Ideals of Medical Pedagogy

A One-Man Dupont Plant

Medical Book News Editorials

Contemporary Progress

Vol. 74 No. 5

Address all Exchanges and Books for Review to 1313 Bedford Avenue, Brooklyn 16, N. Y.

Syntropan has the desirable, antispasmodic actions of belladonna or atropine, but does not depress salivary secretion as actively nor induce mydriasis as readily. When used to induce mydriasis, its influence is not as profound nor as long in duration as that of atropine. The inhibitory action of Syntropan on the parasympathetic innervation of the heart is negligible and not as pronounced as that of atropine. Syntropan has a definite antispasmodic action on spastic smooth muscle, the antispasmodic influence being due jointly to inhibition of the parasympathetic innervation and to direct peripheral relaxing action on the muscle fibers themselves . . . HOFFMANN - LA ROCHE, INC., NUTLEY 10, NEW JERSEY

SYNTROPAN 'ROCHE'—FOR THE RELIEF OF SMOOTH MUSCLE SPASM

EDITORIALS

Rivière

WE regret to announce the death, on March 23, of one who has been a member of the editorial staff of the MEDICAL TIMES for many years and a highly cooperative colleague. Dr. Rivière had attained the age of eighty-seven years.

Sometimes called "the father of electrotherapy," Dr. Rivière was at first a general practitioner but soon engaged in electrotherapeutic research, followed by pioneering in roentgenotherapy. Physical therapy in general engaged his attention and he founded the Physiotherapy Institute in Paris and was Editor-in-Chief of the combined *Journal and Annals of Physiotherapy*. His writings in the fields cited were voluminous and authoritative.

One of the masters of medicine has passed on.

Against Chaos and Death

JOHN J. O'NEILL, Senior Editor of the *New York Herald Tribune*, in his review of "One World or None" (written by a group of atomic energy experts who declare that there is only one answer to statesmen regarding the atom bomb—you'll have to get rid of war), says that the scientists' statement "probably represents the generalized conclusions of the great majority of the scientists not only in the United States but throughout the world. It has required a high order of courage for the scientists, while still under the domination of the military branch of a government still bristling with abnormal war powers, to come before the people with a demand for a warless world in which they can freely work so that their contribution of atomic energy may be made available for the advancement of the human race. If, however, the scientists could understand how utterly helpless the war makers would be without them and how with the same courage and a more scientifically derived program they could wrest from the governmental authorities any concession they wished, they could go far toward making their demands a reality."

Such a stand on the part of the medical profession has likewise been dreamed of and proposed in the past, but the advent of the atomic bomb, with its ominous threat to the civilized world, gives the scientists a special lever that medicine has lacked.

There is, however, no reason that we can think of why medicine should not back up the scientists. Can we not join forces before the insanity of war engulfs us once again? Can not our leaders issue a supporting statement?

The time grows short. Shall it be survival or annihilation? Whatever one thinks of the Pearl Harbor episode, we can not plead any lack of information and warning in the present circumstances.

Crazy Governments

GOVERNMENTS, as well as individuals, can be crazy. We speak of crazy nations sometimes, when it is really the governments that are sick.

The symptoms are apt to reveal themselves in two major ways. On the one hand delusions of grandeur are manifested, and on the other persecutory manias.

The United Nations Assembly is really a voluntary clinic which is making a commendable therapeutic effort, the first progressive step being removal of outmoded restraints on government agents carrying their principals' ailments into the clinic.

It is the ailments now under diagnosis and treatment that lead bewildered and unwilling nations into war, which is the equivalent of insane individuals adopting antisocial courses leading to disaster.

Power-crazy nationalism withdraws from a tolerant pooling of cultures, just as the sick individual shuns free intercourse, loses his sense of realities, and becomes suspicious, cranky, queer and aggressive.

In an atomic age attempted initiation of war would be pathognomonic. The waging of war would be unthinkable on the part of healthy governments. Nations must insist upon good governmental health in this respect. Constitutions should be changed to permit immediate liquidation of governments threatening national betrayal in respect of war-making.

Not that the abolishment of war would give us the world dreamed of in the Middle Ages—"a clearly articulated and firmly ordered whole." We don't want any more New Orders, out of the dream worlds of schizophrenic political messiahs. Liquidating machinery should be developed for governments making their alleged goal a "perfect state."

1945 Mortality

THE Metropolitan Life Insurance Company's study of an American industrial cross section of the population for 1945 shows some interesting facts.

The death rate for influenza and pneumonia was 10 per cent below the previous minimum recorded in 1942, and this despite the epidemic of acute respiratory disease near the close of the year.

The tuberculosis mortality rate declined by no less than 6.6 per cent below 1944, showing that the long-time downward trend in the mortality from this disease is being maintained, which is contrary to expectation.

Measles and scarlet fever gave new lows, while whooping cough and diphtheria rose slightly.

The mortality from obstetric factors declined 12.2 per cent as compared with 1944, a notable achievement.

For diabetes, the rate declined 9 per cent.

The cardiovascular-renal rate remained unchanged.

The death rate for cerebrospinal meningitis was 1.0 per 100,000, as compared with 2.2 in 1943 and 1944 and 0.7 in 1942.

The proportion of fatal cases of poliomyelitis continued low—ascribed to earlier diagnosis.

Motor vehicle accidents gave a higher toll of death in 1945 than in either 1943 or 1944. However, this was considerably lower than the figure for the immediate prewar years.

Homicide in 1945 gave the same figure as in 1944, while that of suicide dropped slightly below 1944, itself an exceptionally low year in this respect.

The Brooklyn Hospital Journal

THE Trustees and the Publication Committee of the Brooklyn Hospital announce that with the return to a peacetime basis publication of the *Brooklyn Hospital Journal* will be resumed in July, 1946.

We welcome the reappearance of this publication because of the outstanding character of the early numbers, whose excellence we believe will be maintained since the same personnel will direct it.

Socialized Medicine and the Veteran

NOTHING is too good for the ill or disabled veteran.

Socialized medicine is not good enough for him.

Yet pressure is being exerted right now to bring the Veterans Administration under national sickness insurance legislation. It is being pointed out to its officials that their responsibility would be eased by what is *potentially* left-wing state medicine.

If the pressure is successful, and compulsory sickness insurance should ever actually lay its dead hand upon the veteran, the Administration would beyond doubt bog down to a pretty low point.

This would be "institutional arthritis" at its worst.

PULMONARY TUBERCULOSIS
MODERN CONCEPT AND RECENT ADVANCES IN TREATMENT
IV

I. Ellis Rudman, M.D.
Philadelphia, Pa.

PNEUMOPERITONEUM has come into use in recent years for a selected number of cases of pulmonary tuberculosis.

Pneumoperitoneum is reserved for patients in whom artificial pneumothorax or other orthodox forms of collapse therapy cannot be employed.

The instillation of sterilized air, oxygen or nitrogen into the abdominal cavity has been used for a good many years as an aid in the diagnosis of obscure abdominal lesions and for the treatment of intestinal tuberculosis. Its adaptation to the treatment of pulmonary tuberculosis is of more recent origin. A voluminous literature has accumulated on this subject in the last few years. The reports on the efficacy of this form of treatment run the whole gamut of enthusiasm to pessimism.

The advocates of pneumoperitoneum claim that the beneficial results brought about are due to:

1. Elevation of both hemidiaphragms giving rest to the diseased lung.
2. Lymphostasis, which in turn promotes tissue fibrosis.
3. Pulmonary congestion and anoxemia which in turn prohibit the growth of tubercle bacilli in the tissues and hasten the reparative processes. They are supposed to affect especially basilar pathology.

However, these theoretical considerations do not always work out in practice.

(a) Mobility of the diaphragm is impaired or limited but rarely abolished, even though large amounts of air are instilled into the abdominal cavity and intra-abdominal pressure is raised to a high degree.

(b) In advanced cases, subdiaphragmatic adhesions limit the rise of the diaphragm.

(c) In advanced cases, because of the fibrotic character of the lesion and its resistance to compression, even though a hiatus is created by the pneumoperitoneum showing the presence of air between the liver and diaphragm, and between the stomach and the diaphragm, the actual rise of the diaphragm is more apparent than real. The intra-abdominal pressure causes a downward displacement of the abdominal viscera.

(d) Extreme pressure affects the abdominal viscera and interferes with the patient's intake of food and hastens the clinical downward trend. Any attempt to make the pneumoperitoneum effective and to stretch adhesions by the increase of intra-abdominal pressure causes excruciating shoulder girdle pains in many advanced cases.

But, while in the advanced cases the subdiaphragmatic adhesions, the extent of the lesions in the lung tissue and the tonus of the diaphragm may nullify whatever benefits there are to be obtained from pneumoperitoneum, a far different picture and more salubrious results are brought about when pneumoperitoneum is used in the early or moderately advanced case to enhance the value of phrenic neurectomy. No matter how poor the results are from a phrenic operation, the use of pneumoperitoneum greatly enhances its value.

PNEUMOPERITONEUM is a far more formidable procedure than pneumothorax, therefore the procedure of pneumoperitoneum should be done with great caution and care. Nitrogen has been resorted to as the agent to be used for pneumoperitoneum for the reason that this gas is more slowly absorbed and refills are less frequently required. The skin sterilization is done on a small area on the abdominal wall with meticulous care. Tincture of green soap is used followed by alcohol and then the area selected is painted with tincture of metaphen. The point chosen for the insertion of the needle is about one inch above and to the left of the umbilicus. The skin is infil-

trated with 2 per cent procaine hydrochloride solution. The tubing is attached to the pneumothorax apparatus in the usual way and to the free end of the tubing is attached a three-way petcock. A 5 cc. Luer syringe partly filled with procaine solution is attached to the petcock and a Vim 19 gauge 2½ inch needle is used. Insertion of the needle through the abdominal wall is made gradually. There is often a sensation in the hand of the operator that tells him when the peritoneum is punctured. To make certain that the needle has traversed the abdominal wall and is in the peritoneal space, a minute amount of nitrogen is allowed to go throug the tubing and a reading is made by means of the water manometer. If the needle is in the peritoneal cavity, there is very little movement of the water in the manometer but, if the needle is still in the abdominal wall, there is a sudden rise of the water level on the positive side. Further insertion of the needle is then permissible and again if a reading is made, it will show a sudden drop of the manometric readings to zero or to a minus one or a minus two. We are then ready to allow more nitrogen to enter the abdominal cavity. As a rule 500 or 600 cc. of nitrogen is used for the initial instillation.

THE drawbacks to the administration of pneumoperitoneum are that:

(a) The usual water manometer is not sufficiently sensitive to give us an accurate gauge of the variation and fluctuation of the intra-abdominal pressure.

(b) Even the most careful operator will frequently cause infiltration of the abdominal wall with air or nitrogen and a resulting subcutaneous emphysema.

(c) We have gathered from the literature 4 cases of air embolism, 4 cases of injection of air into the spleen and one death due to peritonitis.

(d) A study made of the local effiects of long-continued pneumoperitoneum showed that there were definite signs of peritoneal irritation and that the formation of ascites, occurring during the course of treatment, is analogous to the formation of an effusion in the course of pneumothorax treatment. However, the need for aspiration of fluid from the abdominal cavity rarely arises.

THE place of pneumoperitoneum in the treatment of pulmonary tuberculosis is now at the stage where pneumothorax was twenty-five years ago. Its use as a last resort measure and the paucity of results obtained in such cases will eventually cause this method to be regarded with disfavor and probably thrown into the discard. Pneumoperitoneum cannot be expected to close thick-walled cavities or be of any value in the far advanced cases where the spread is generalized in both pulmonary areas, any more than pneumothorax can be utilized in such cases. To resort to pneumoperitoneum where symphysis of the pleura prevents the possibility of pneumothorax or other forms of collapse therapy would only be an unnecessary expenditure of effort and of no lasting benefit to the patient. The indications for pneumoperitoneum must be clear-cut and the cases properly selected.

The indications for pneumoperitoneum in the treatment of pulmonary tuberculosis may be summarized as follows:

(1) As a trial measure to determine diaphragmatic mobility and freedom from interfering subdiaphragmatic adhesions prior to phrenic interruption.

(2) In patients in whom a breakdown and reactivation of the tuberculous process have occurred some time after an effective phrenic operation, it may be possible by means of pneumoperitoneum to prevent reopening of the cavity.

(3) Its greatest value lies in its ability to enhance the effect of the diaphragmatic rise following phrenic interruption.

(4) To prepare the patient for radical surgery and to make the lesion quiescent in less time than could be accomplished by bed rest alone.

(5) Pneumoperitoneum per se is a measure of limited value. As the sole therapeutic measure for the treatment of pulmonary tuberculosis, its results are neither positive nor its benefits lasting.

THE two cases cited are illustrative of what, at times, can be accomplished by means of pneumoperitoneum. These cases were moderately advanced. Both patients were on the downgrade. The tuberculous process was active—the sputum was positive for tubercle bacilli—the Gaffky count was high. The alternative to pneumoperitoneum was thoracoplasty. Neither case was suitable for such a procedure at this time. Both cases gave a history of previous long hospitalization in excellent institutions. It is claimed that pneumoperitoneum exerts its greatest benefits on basal lesions. In these two cases the brunt of the tuberculous infection was in the upper part of the chest. The cavitation was extensive and occupied the apical as well as a part of the subclavicular zones. In neither case was there a marked rise of the hemidiaphragm following phrenic interruption. It was only after pneumoperitoneum was instituted that the tuberculous process began to show evidence of retrogression.

The present wave of "popularity" of pneumoperitoneum is not without its "seamy" side. Unlike pneumothorax, pneumoperitoneum can be established in the majority of cases in which it is tried. Whether beneficial or not is another point. Suffice it to say that the peritoneal space can be entered and air or nitrogen gas instilled. It is this certainty of always being able to give pneumoperitoneum that has led to the abuse of this method of treatment. Whenever one hears of a clinic or individual physician treating 90 per cent of his cases by means of pneumoperitoneum and only 10 per cent by pneumothorax, the question arises as to how many really show clear-cut indications and how many are benefited by its use. At the U. S. Army Induction Center, we came across many cases of pneumoperitoneum induced for Ghon tubercles, for old apical fibroid tuberculosis, for calcified hilum nodes.

Case 1. Betty H. Age 27

She was taken ill in December, 1940. Her first symptoms were slight cough and some expectoration and severe night-

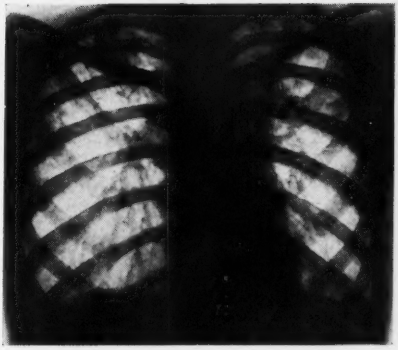


Fig. 1. Betty H. Age 27 6/28/41

Shows an exudative cavitary lesion involving the left upper lobe. A cavity about 4 x 5 cm. is located in the apex and in the subclavicular zone. It is near the periphery of the lung. There is scattered infiltration throughout the right side but no evidence of cavitation.

sweats. She was admitted to the Jefferson Hospital where artificial pneumothorax was established on the left side. The collapse was ineffectual because of numerous adhesions. A large cavity in the left upper lobe remained open. Thoracoscopy was done and the adhesions were found to be inoperable. The pneumothorax was then abandoned. Because of the active disease in the contralateral lung, she was not considered a suitable case for thoracoplasty. She remained at the Jefferson Hospital until June, 1941. She came under our care at the end of June of the same year. At that time physical examination confirmed by x-ray showed an acute exudative cavernous tuberculous process in the left upper lobe and scattered infiltration throughout the right side. In addition to the above mentioned pathology, she exhibited signs of bronchial asthma. Tests with various allergenic extracts were done, and she was found to be very sensitive to household dust and ragweed. Desensitization treatment was started, to which in time she responded well. The asthmatic wheezing was finally brought under control. On July 11, 1941, the phrenic nerve on the left side of the neck was crushed. Com-

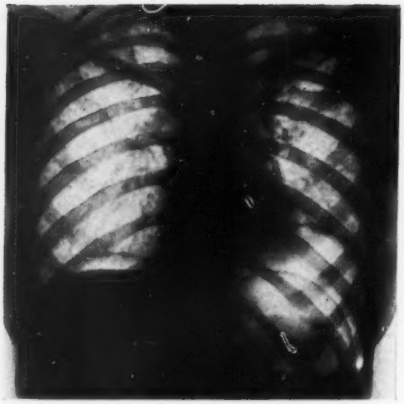


Fig. 2. Betty H. 11/3/41

Shows the establishment of a pneumoperitoneum. A phrenic crush was done on the left side in July, 1941. Both hemidiaphragms are elevated, the left more than the right. The cavity in the left upper lobe is more sharply outlined and definitely smaller in circumference. A hiatus is created by the presence of nitrogen gas between the liver and the diaphragm and between the stomach and the diaphragm. The shape and contour of the upper margin of the stomach are sharply outlined.

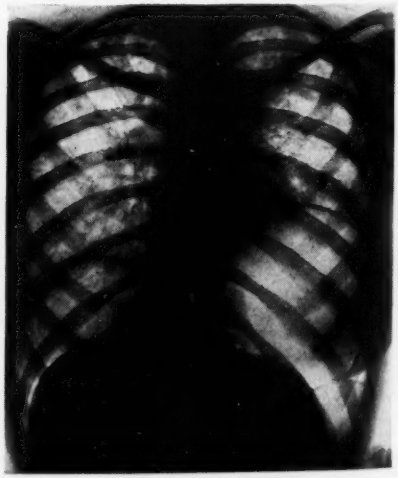
plete paralysis of the left hemidiaphragm resulted. A slight rise of the left hemidiaphragm ensued. The cavity in the left upper lobe was not in any way affected by this procedure. On November 3, 1941, pneumoperitoneum was instituted. For the first treatment, 350 cc. of nitrogen was instilled. As the diaphragm became more elevated during subsequent treatments, a remarkable change took place in this case. The cavity in the left upper lobe visibly began to shrink. Cough and expectoration became markedly reduced. At the end of 1942, all signs of cavitation disappeared and sputum conversion took place. In February, 1943, the last pneumoperitoneum refill was given. With the cessation of treatment, the left hemidiaphragm descended to the pre-pneumoperitoneum level. Apparently, the crushing of the phrenic nerve was done too thoroughly and a permanent paralysis resulted. The patient, however, has not experienced any shortness of breath or discomfort at any time since the operation. She is now able to do light housework and she has gained twenty-six pounds in weight. The treatment with household dust and pollen extract is being continued.

Fig. 1. Betty H. Age 27 6/28/41

Shows an exudative cavitary lesion involving the left upper lobe. A cavity about 4 x 5 cm. is located in the apex and in the subclavicular zone. It is near the periphery of the lung. There is scattered infiltration throughout the right side but no evidence of cavitation.

Fig. 3. Betty H. 1/10/42

Shows marked elevation of both hemidiaphragms. A large hiatus has been created by the nitrogen gas on the right and on the left side of the abdomen. The left pulmonary field is nearly 50 per cent compressed by the elevation of the left hemidiaphragm. Marked absorption of the exudative process has taken place on the right. The cavity in the left upper lobe has become very shallow and nearly a 50 per cent reduction in its circumference has taken place.



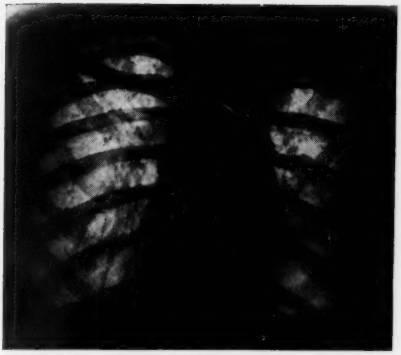


Fig. 4. Betty H. 10/5/45

This film was taken two and a half years after the abandonment of treatment. There is no longer any evidence of cavitation in the left upper lobe. Healing of the tuberculous process has taken place by absorption and by calcification. The left hemidiaphragm remains elevated.

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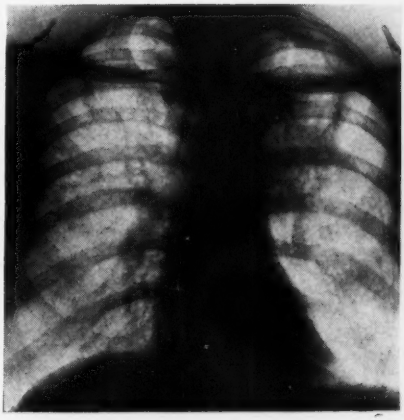
Case 2. Stephen B. Age 41

This case presents many interesting features. He was taken ill in July, 1942. The diagnosis of an acute tuberculous pneumonic process involving the whole left pulmonary field was made at the Montgomery County Hospital in Norristown, Pa. At the end of a month's time, he was transferred to the Hamburg State Hospital. At that institution, pneumothorax was instituted on the left side. Slight improvement resulted in the patient's condition. The temperature became less hectic and the debilitating night-sweats ceased. However, the lesion went on to cavitation. Through the kindness of the superintendent

Fig. 5. Stephen B. Age 41 3/29/43

Shows the presence of a pneumothorax on the left side collapsing about 10 per cent of the pulmonary field. A multilocular cavity is seen in the left upper lobe. It is bound to the dome of the thorax and laterally to the first three ribs.



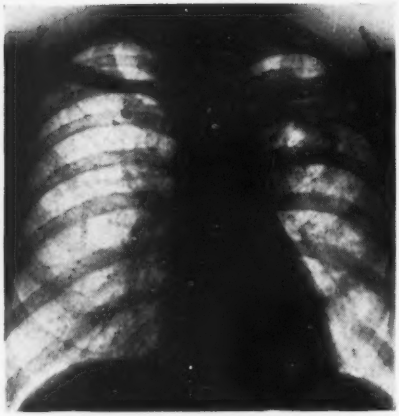


Fig. 6. Stephen B. 2/3/44

This film was taken after the lung had been allowed to re-expand. We now see a fibrocaseous cavitary lesion involving the upper third of the left pulmonary area. Two distinct cavities can be seen in the left upper lobe.

of the Hamburg State Hospital, I was able to obtain an x-ray film taken before he left the sanatorium. He was told that pneumothorax would be ineffectual in his case —that the lung must be allowed to re-expand—and that eventually he might become suitable for a thoracoplasty. He then left the hospital and came back to his home in Bridgeport, Pa., to continue the rest cure at home. He came to our attention in February, 1944. At that time, physical examination confirmed by x-ray revealed a fibrocaseous cavitary lesion throughout the left pulmonary field. A cavity about 4 x 6 cm. in diameter occupied the apex and a part of the subclavicular zone. A smaller cavity was also present at the level of the second rib anteriorly near the mediastinum.

On February 8, 1944, a phrenicectomy was done on the left side of the neck. Because of the extent of the cavitation and the length of time it would probably take to bring about any beneficial results, it was decided to create a permanent paralysis of the left hemidiaphragm and, therefore, a phrenic exeresis was done. Pneumoperitoneum was instituted a few days later. Though the patient's pneumoperitoneum refills are still being continued, the results so far obtained are so gratifying that it is worth-while to record this case. The original impression obtained in studying the film obtained from the Hamburg State Hospital was that the cavity walls were thick and would resist closure by pneumoperitoneum, but such did not prove to be the case. By the end of 1944, all signs of cavitation disappeared. The patient is now gainfully employed. Pneumoperitoneum refills are given about once a month.

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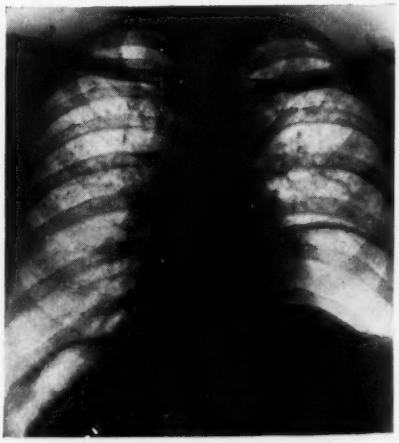
Shows the presence of pneumothorax on the left side collapsing about 10 per cent of the pulmonary field. A multilocular cavity is seen in the left upper lobe. It is bound to the dome of the thorax and laterally to the first three ribs.

—Concluded on page 146

Fig. 7. Stephen B. 4/12/45

Shows the appearance of the lesion fourteen months after the institution of pneumoperitoneum as a procedure supplementary to phrenic neurectomy. No evidence of cavitation can now be observed. The left hemidiaphragm is markedly elevated as compared to the right. Marked fibrosis of the tuberculous process has taken place.



IDEALS OF PEDAGOGY IN THEIR APPLICATION TO MEDICINE

James Creese, Litt.B., M.A., LL.D., Pd.D.
President of the Drexel Institute of Technology

Gentlemen—Doctors of Medicine:

I HAVE the honor of saluting you in behalf of your future patients, to bid you welcome to your profession, with some of the gladness, with great confidence in you, and with that prayer for your success which you will read often hereafter in the troubled faces of hundreds who will welcome you at their doors, believing that you bring relief to those who suffer.

In your ministry, I have the temerity to bid you to be *gentle* men, as well as scholars and physicians, so that the cool hand of skill may have also the touch of compassion.

Yours is a true profession, one of the three that we have long called the "learned professions". The avowed servant of the church and the sworn servant of the law share with you that honor. Like them you have an oath to serve some cause other than personal advancement or private gain. It is no deprecation of the divine institutions or of the social establishments those others serve, the priest and the lawyer, to suggest that you have in your profession a merit different from theirs and even more humane; for while they are pledged to serve men through institutions, you are pledged to care for men directly—to care for their very persons, each man, woman and child in his own right to life, and each for his own particular needs. Neither creed nor tradition, neither revelation nor precedent has the right to lay a restraining hand upon you in the just and conscientious practice of your profession.

IN preparation for this address, I thought I should read a little medicine. It would add to the effectiveness of the performance, it would be good drama, if I could speak with the vocabulary of medical science.

I took as my first source of inspiration the monthly medical report which comes to my desk from the college physician. Sure enough, there was a long list of medical terms. In the course of the month, Dr. Arnett and his associates had identified afflictions, mostly petty, enough to fill a small sized medical dictionary. These afflictions were of a kind so common and recurrent, that the list had been mimeographed. All the reporter had to do was to write in a number to show the incidence of the particular complaints in any month. "Housemaid's knee" was not there. I looked in vain for pronounceable disorders. The list was full of sound and fury but it signified very little to me. Hoping to find some medical term I could utter, I worked back through the list—it was arranged alphabetically—until I came to the first. And what do you think was the first word on the list of human miseries? It was the doctor's word for a consultation, Advice.

That is an ominous word with which to confront a man about to make a commencement address.

I examined next the books on the shelves at home, hoping to discover there some Baedecker for a layman about to venture into the realms of medicine.

I found six russet volumes, inherited from doctor fathers-in-law of several generations. They were:

1. *Mackintosh's Practice of Medicine,* with Morton's Notes and Additions, published in Philadelphia in 1844.
2. Dewees' *Treatment of Children,* published in Philadelphia in 1829.
3. *Wistar's Anatomy,* in two volumes, published here in 1823.
4. *Anthropologia Nova; or a New System of Anatomy,* describing the Animal Oeconomy, and A Short Rationale of many Distempers Incident to Human Bodies, by James Drake, published in London in 1717.

Commencement Address, Hahnemann Medical College, Philadelphia, March 12, 1946.

5. And finally this book quaintly entitled *The Anchient Physician's Legacy to his Country* Being what he has collected himself in Forty-Nine Years Practice, by Thomas Dover, published in London in 1732.

Of all these, the one that I found myself reading with the greatest pleasure and understanding was Mr. Dover's "account of the several diseases incident to mankind, described in so plain a manner that any person [including myself] may know the nature of his own disease—together with the several remedies for each distemper, faithfully set down." The price of that volume, stitched, in Pater Noster Row, at the Lamb in the Old Bailey, and at Homer's Head over-against St. Dunstan's Church, was five shillings; 214 years ago. But to me, now, it was priceless, for it would permit me to speak with authority on the state of modern medicine.

I mean to read a few pages to you (if I can control those 18th century "Ss", which look life "Fs". They have an hypnotic effect on me. When I come to that odd old S in the text, I find that I have an ungovernable impulse to lisp). So:

(page 6)

"There are three cauſes of Shortneſs of Breath; Inflamation, Convulſion, and Plenitude: Bleeding in Convulſions, if it has not been, ought to be exploded; and in Fulneſs, occaſioned by Dropſies, it is pernicious to the laſt Degree."

Well, it's a satisfaction to know that someone has finally come out against Bleeding, at least in Convulſions and Fulneſs.

Dr. Dover is not bigotedly opposed to bleeding. He cites, for instance, the case of John Dineley Goodeere, Esq., of Charlton in Worcestershire, who was seized of a violent fever. By the time the young man's father, Sir Edward, called in Mr. Dover, things had come to a pretty pass:

(page 145)

"His Eyes were set in his Head, his Jaw fallen, his Tongue directly black and hard, his Face as black as an Indian, with round Drops upon it as big as Pease or Pulse. The Apothecary being present, I asked him if he blooded. He told me, Yes; and Accordingly got everything in order for it. I bid him take Care to make a large Orifice, which he did. He asked me how much Blood he must take away. I answered I could not tell. He said he had taken off twelve Ounces. I said, Let the Patient bleed on. The Apothecary now told me he had drawn twenty Ounces. Then I discerned something of a Pulse coming on in my Patient. In the Conclusion, he bled to forty-eight or fifty Ounces. The Sweat went off, and his Face came to its Color. Whilst he was bleeding, I got a cool Tankard of Rhenish Wine, Water, and Lemon, which held near three Quarts: I raised him upon his pillow, and gave him about a Pint-Glassful; and immediately after he began to move his Eyes, and close his Jaws. In a very short Time after, I gave him a couple of Glasses more. He then fixed his Eyes hard upon me, put his Hand out to me, and said, *Is it you, my dear Friend?* I asked him *If he could drink.* He answered *The Ocean. . . .* In one Hour, or thereabouts, he flung his Clothes off the bed, put his feet in his Slippers, called for his Night-Gown, walked to the other Side of the Room, set himself down in a two armed Chair, *Now, my dear Friend, (says he,) we will have one Flask of Claret together.* I told him, I would drink a *Flask of Claret;* but that he must stick to his Cool Tankard.

"The next Morning, when I came to wait on him, he was down in the Stables amongst his Horses, without a Cap, having nothing on but his Night-Gown and Slippers. I asked him, *How he did?* He said, *Never better in all his life.*"

This 18th century doctor's report is like a scene from Fielding or a drawing by Hogarth. It is lusty, but would you not call that a desperate way to practice? That's what some of Mr. Dover's critics called it, two hundred years ago. Elsewhere in his books he writes as one who had a nasty time with his colleagues.

THE history of the profession of medicine, from Galen through Brown to Sister Kenny, has its casualty list of innovators, its roster of tournaments, its broken lances and broken heads, no less than does the profession of arms.

The heresy of one age is the doctrine of the next; and then the doctrine of that age may have nothing better than derision in times to follow or at best find a subordinate place in the body of medical knowledge. Each generation learns by the mistakes of its fathers—and by its own mistakes. Practice perfects knowledge.

Among your kind, the speculative and the practical cannot be separate. Your scholars and your teachers walk the wards. There is no cloistered seclusion for them. You, their disciples, are apprentices at work even while you study. The customs of your profession and the laws of the state require that you must complete your apprenticeship as internes in the work rooms of the hospital and under the watchful eye of experienced doctors and nurses, before you may stand alone as qualified practitioners. Even in your student years and at that age when the textbook and the theory are apt to be accepted as having an absolute authority, your theories meet the daily test of applicability. What does this patient suffer from? By what immediate and particular treatment will he be benefitted? Here is the very man to be cared for. No vicarious treatment will serve. What will your knowledge permit you to do?

Such helpful circumstances for learning are contrived with difficulty in the training of men for other callings. The student of the law has his case books, but he does not stand in court with the living case before him. The student of economics may scrutinize an audit, but he does not sit in feverish conference hearing in plain words the complaints of the union organizer. The student of engineering has too little chance to observe at first hand, in the long ward-like rooms of the assembly line, the actual workings of the principles of production of which he has read and heard in the class rooms. He may be given the advantage of a term in the factory, alternating between class room and plant so that each is more meaningful for him, but even so, there is for him some dichotomy, some arbitrary and unnatural separation between theory and practice. He serves under different masters in the class room and the plant. His tutors and instructors do not go with him. It would benefit them if they did, if teachers too could move readily and of necessity between the library and the shop.

TWO ideals of pedagogy seem to me to be exemplified in the provisions made for medical education:

1st, the ideal of continuity in teaching and experience, of which I have just spoken, a union so intimate that it is difficult to say where the medical school stops and where the hospital begins. And

2nd, a newer ideal or concept, favored now by universities and medical associations, of post-graduate studies through which the practicing physician may steadily refresh and extend his knowledge.

The universities and colleges of America have played an honorable part in satisfying the sense of our people that knowledge and the training or the development of intellectual interests do not constitute a monopoly for the so-called educated classes. No social phenomenon of the past half century has been more significant of the growth of the spirit of democracy than has been shown in the popularization of higher education. The extension of university teaching to such multitudes on the campuses, and far beyond the confines of college campuses, has established channels for the reclamation of great and fruitful human areas. It has not been done without some complaint of popularization in a bad sense of the word, not without some protest against a feared cheapening of education, against education "spread thin," and education without intellectual discipline—"without tears." But if one wishes to realize what has been accomplished in university extension and in the whole movement of adult education, let him count the school teachers who have added to their effectiveness by study in summer schools and in evening classes; and

then let him try to estimate what it has meant to the farming population to have had created in this country, between the two world wars, a system of agricultural extension which carries the influence of the agricultural college and the experiment station into every county and to almost every farm.

The natural constituency of a college or university is not the whole population of the area in which it lives. The college of agriculture has its market for specialized knowledge among the farm people. The college of engineering may serve, if it will, the entire community of industrial technicians, industrial workers, and industrial managers. The college of medicine has its following among the doctors, the nurses, the administrators of hospitals, and the multiplicity of agencies engaged in the work of public health. The broadening of professional and vocational education, both in school and in the field of work, is a task worthy of our institutions of higher learning and one for which they are peculiarly well fitted.

MUCH more than the layman or even the educator realizes is being done in this special field of university teaching. For instance, in medicine and in public health. When I had an assignment some years ago to study the extramural activities of colleges and universities, I was particularly impressed by the extent and substantial organization of postgraduate medical study in which universities cooperate with national, state and local medical associations. Associations of engineers, lawyers, journalists, librarians, and other professional groups need to observe what has been quietly accomplished by the medical associations.

In one year, 1939-40, the Council on Medical Education and Hospitals could report that 129 formally organized programs for the continuation study of medicine had been conducted in 41 states and the District of Columbia. The estimated attendance in itinerant courses was 20,213; in clinical courses, 15,399; in graduate assemblies, 16,400—a grand total of 52,012. In Virginia, for instance, over a period of seven years, 24 per cent or more of all the doctors of the state had attended two sets of lecture clinics, an evening a week through five weeks for each subject, on obstetrics and pediatrics. Similar reports can be made for other states—Michigan, Wisconsin, California, Louisiana, Mississippi, North Carolina; and work is done almost invariably as a cooperative enterprise of medical associations and the university hospital.

I mention this as a challenge to your imagination. Do not close your books as if you had now mastered your subjects, and do not close your minds.

IN this past half century, the facilities for medical education have been immeasurably improved. As research institutions and hospitals have been added to medical schools, side by side, a daily interplay between theory and practice has been in great part achieved. Now, for the future, some of the most exciting work to be done in the dissemination and use of medical knowledge is in the range of what is called, technically, Forensic Medicine or Medical Jurisprudence.

We are assured under our form of government of our inalienable rights to "life, liberty, and the pursuit of happiness." First among these is Life. If, as we believe, our basic ideas in government stem from our Declaration of Independence, then we properly require of the State a concern for the conditions of health.

In the view and philosophy of democratic government, a sacramental virtue is associated with the individual life. The life of the humblest man is precious. If it is denied to him, by indifference or brutality, the State has failed in the first of its great functions. You and all men of your profession are accredited by the State to serve our historic purpose that men may be born and live their lives through under whatever conditions we can make that will be most favorable to each man's inalienable right to life.

Therefore, within your purview are all the matters of public health.

You are not members of a narrow union of workers.

You do not hold diplomas entitling you to a property interest in the illnesses of mankind.

You do not belong to a beleagured fraternity defending a fortified stronghold. You have instead innumerable allies waiting eagerly to join you in an open action against all the forces of illness and disease. Call them to you and give them the arms they need.

The allies to whom I refer include the laboratory workers of the public health service who are subject to a high and conscientious discipline; the health officers and the sanitary inspectors who have an immediate responsibility for the health of a community; and particularly the public health nurses who are the county and ward leaders and the block captains, in the organization for public health.

If all these are to be successful in their part of the everlasting campaign for health they must be armed—and so must doctors—by more than instruction in the methods and techniques of their public functions. They and the doctors, under the leadership of the medical profession, have need for a knowledge of the terrain of general economic and social conditions so that the enemies of health may be routed from infested slums and from remote, neglected shires.

THE war has jolted many of us out of our accustomed ways. Particularly has it shown, in its statistics of the draft, what a waste of human resources we indulge in, how scandalously we have allowed young people to grow to the age of citizens and soldiers still defective, decrepit, and even deranged. The cost of an organization for health, great as it may be, is a trifle compared with the cost of neglect. We lose much by the waste of our best resources in manpower. We lose also by the enormous cost of accepting as public wards all those who have not the physical and mental health to hold a place in economic life.

The war may at last cast some light into darkness. It has awakened us to an understanding of the problems of mental health. We have our PNs, as well as our men disabled physically to the point where they are not fit for civil or military employment. It is some gain to know that we have them. We cannot dismiss them into up-state hospitals and leave them there—in the custody of the State, but hardly in its care.

It has struck me as a good omen, favorable to the veterans and favorable to the improvement of hospital and health services, that the Veterans Administration under General Bradley seems to seek, on the one hand, those services which the massed skills of the university hospitals can offer, placing Veterans' Hospitals in the neighborhood of university hospitals; and seems to seek, on the other hand, as in the Michigan experiment, to invite the communities to marshall their local medical forces for the benefit of the veteran in his own home town and to use them in an organized, collaborative effort of specialists, for the benefit of the disabled. Out of this national program, set up for the veterans, may emerge a better national program for public health than we have yet had, one which uses the university centers for those acutely in need of the highest and most up-to-the-minute arts of care, and uses likewise the community association of doctors and nurses, better organized and better equipped than they have been, for the men who can be best cared for and most happily treated in their own home towns.

These two projects, for the reinforcement of university centers and for the extension of scientific knowledge into every county and town, invite the interest of young doctors.

A WEEK ago the war-time Prime Minister of Britain spoke in Missouri, from the rostrum of another Westminster, a small college of that name in the little town of Fulton. Country folk drove into town from 50 miles about to cheer him along Main Street and to hear him in the gymnasium. The ladies of the Methodist Church served the supper. There, in that isolated village, in the middle lands of the country where parochialism and isolationism are supposed to flourish, he spoke for

—Concluded on page 146

IMPORTANCE OF STUDENT RESEARCH IN THE MEDICAL SCHOOLS

Wallace Marshall, M.D.
Mobile, Alabama

THERE are times when many a practicing physician may ask himself what is apparently wrong with his professional knowledge, his medical education and his scientific background. Such an inquiry usually stems from inadvertently stumbling through a particularly difficult case, when one's confidence in one's ability may drop to a low ebb.

In discussions with medical colleagues, one gets the impression that something may have been lacking in their medical education. These physicians are eager for information, to be sure, but some factor, a spark of something or other, seems to be wanting in that they may feel that they have not kept pace with medical progress since their graduation days (1).

WHAT I have to say may be productive of some serious dissent among members of the medical fraternity. So, let me say at the outset that I welcome divergent views which have to do with the points which I shall discuss. One finds it rather tedious and eventually stifling to find that colleagues agree continually with one without raising constructive criticism on conflicting topics. Open, frank discussion has its merits, and through such a process is progress developed (2).

These various points, which are to be discussed, have been accruing over some years which have been spent in the teaching of medical students and in the actual practice of medicine. I have been fortunate enough to have given much time in the discussion of these matters with various medical students. These youngsters are experiencing the many hardships which are to be found during the extended years in obtaining a professional education, and many of them are actually bitter on some of the aspects which have to do with their education.

I, for one, feel that some of the points these embryo physicians have raised are very worthy of serious consideration, and I have attempted to keep these matters firmly fixed in my mind, so that, when the time presented itself, I could present them to my colleagues with the sincere hope that something concrete and constructive might be done to rectify these errors in our current medical education. In my humble opinion, this time has certainly arrived.

It is, then, my plan to present these several topics as they appear to me. Let us hope that healthy discussions will follow as a result of this paper. My thesis may be shown to be in error, in which case, I shall certainly be happy to change my current views.

LET us begin with the problems which confront most medical students. Any individual, who has been subjected to the grueling four years of a formal medical education, will usually agree readily that this study is most difficult, to say the least. In order to qualify for the medical course in a strong school of medicine, one has to be a very good student. However, some youngsters enter this course through various connections which their parents or guardians may have with certain authorities in high places, but such cases are luckily in the minority.

Most students will state that the first two years, namely, the pre-clinical years, are particularly difficult. During that time, they are subjected to intensive courses in anatomy, physiological chemistry, histology, neurology, physiology, bacteriology, pathology, and other grueling studies. The typical teacher has an inherent feeling that the course, which he teaches, is by far the most important in the entire school. Some of these professors actually make their courses as difficult as possible in order, they will tell you, to "weed out the poor students."

But what are these men teaching? They are teaching facts which their students are

supposed' to assimilate like a sponge. At various times, the sponge is squeezed, and the information runs out freely during the examination periods. If a particular student possesses a good memory, he is a good student. But is he? He can, in parrot fashion, recite the necessary information which he has read or heard during the lecture hours. If he remembers what he is supposed to, he is classed as an adequate student. Again I ask, is he?

I have no aversion to the use of Doctors of Philosophy as teachers in the various basic science courses. Many of these men have made brilliant teachers, even if they possess no particular interest in bedside medicine. They usually have a particularly good grasp of their subjects, and I applaud such teaching efforts if they do not stress the unimportant points rather than the practical considerations. Let me exemplify this point. If a teacher in physiological chemistry, for example, insists upon his students learning involved formulas, and if this particular professor does not stress the practical points in that course, his students will be wasting their time, even if they can write formulas for carotene, ergosterol, and the like. If they do not know what has happened in the body to make a patient a diabetic, the students will have missed the forest for the trees, to use a trite figure of speech. If the students do not remember the chemistry of digestion or have no idea of the significance of a high creatinine reading of a blood sample, yet can write a long chemical equation or explain the derivation of the pH of the blood, this course will be a loss to them in later years. Such events, as I am now discussing, have happened and are taking place continually in various medical courses.

I have had the opinion, which I still hold, that some teachers insist upon learning rather unimportant points so that they will be known as "tough" teachers. Such a status apparently pets their egoism, for they seem to derive marked satisfaction from this knowledge. Such actions do students no particular good. As a matter of fact, in my opinion, these teaching methods are dangerous for several reasons. This extraneous, difficult matter clutters up the students' minds. It confuses them, for it forces the students to cram for examinations, and they promptly forget this questionable information after they finish the course. Important points of the course are lost by the necessity for passing these examinations. Furthermore, along with other damaging results, these students, like other normal students, have a saturation point. Other courses will suffer by such actions. I have known a few students who have carried mental scars from such tactics, in the form of extreme insommia and other nervous manifestations.

I have observed some students, with an investigative type of mind, actually being insulted by the teacher before the entire class, because they questioned certain matters in the course of their studies. Such a practice is as brutal as one can imagine. For my part, I would heed these questions and foster such thinking, but since the medical curriculum is so crowded, such an approach is sometimes shunned. That is deplorable. When a medical student thinks for himself, such a student stands far above the class in potentiality, because this youngster possesses that rare ability which is so necessary in the making of a medical investigator. Most students are parrots. They throw back what they have absorbed, but given a problem which may take reasoning, they are wholly confused. It is very much like having a musical genius, but preventing the child from access to a musical instrument or music itself. Medicine cannot progress if we take away imagination, intellectual drive and an investigative approach to our educational system.

My approach to such a topic is to put the inquiring student at work on the problem or question he has raised. He will obtain the fundamentals of the course along with this extra work because he will develop a love for the entire course. I have observed this work many times. Do not extinguish the flare for research when it exists in students. Such a practice will make them drones and not scholars.

In my own case, I was given several opportunities for investigative work while I was taking several courses in medical

school. Other students, who possessed an investigative mind, worked in the laboratories with me. I found that this work proved to be the highlight of my medical school days, for we worked hard, but we obtained far more information than did the other students. Most of my classmates, who took part in this extra investigative work, were outstanding students, and they carried this extra training to good advantage in other courses and then into their medical practice long after they graduated. Many of the so-called "bookworms" may drop later into medical oblivion. But those students, who show an investigative trend in their thinking, may not be strong students, yet they possess a spark and an intellectual drive, and, when nurtured, may develop by additional training, so that they may receive many extra opportunities for advancement at a later date. They may learn to think for themselves. They will not be upset when they become confronted with perplexing problems. They will develop assurance in themselves which the other students may have not learned during their medical studies.

LET us turn now to the men in the private practice of medicine. There are some doctors who have not followed the rapid advance of medical science. They may have attempted to keep up with ever-changing medical therapeutics the easy way. To put it curtly, they may have obtained what newer knowledge they possess through detail men from the various pharmaceutical firms. It is not my intent to belittle the detail man. After all, his job is to sell the merchandise he has to offer. He is usually a registered pharmacist who has grown tired of selling cosmetics and ice cream sodas. However, some detail men are well trained in their field, and it certainly would be unfair to brand them in an unfavorable way. But the information, which these men can give the doctor, is of the questionable variety. In my opinion, it would be far better if the doctor would consult the Index Medicus and obtain some journals which deal with the subject under question.

Some physicians are so busy with their practices that, by the time they come home, they are very tired and do not feel inclined to study modern medicine and surgery. It takes a physician with a sincere interest in his profession to attempt to keep up with medical progress. The usual answer is given, by many tired doctors, that the older methods have given them such outstanding results that they are not inclined to change and try the many "new-fangled" therapies.

However, if the physician has taken the investigative trend with him into his practice, he will certainly find ways and means to continue his studies. He will keep adequate case histories so that he can publish the results of his own research. He will note certain data after the patient has retired from his office. He will cut his lunch hour shorter to read the current opinions on his particular problem, and he will see that he obtains the journals and textbooks which will bring him the information he requires. He will not care too much about his golf, nor will the fishing urge interfere too much with his continual search for knowledge. In other words, he may find himself a leader in his profession before he realizes it.

From what has been described, my readers may realize that the chance for medical drones to develop, after graduation, is lessened markedly if we foster the investigative approach in medical students throughout the various medical schools. Medical research depends entirely upon medical investigation, and if we do not develop this in our embryo doctors, our profession will suffer when these men later become practitioners.

As in other fields of endeavor, progress and the advancement of medicine rest upon the proper development of our medical students. Let us spare nothing to support the continuance of medical progress and the continual production of intelligent, scientifically minded doctors.

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CULTURAL MEDICINE

SAMUEL GUTHRIE, THE ONE-MAN DUPONT PLANT (1782-1848)

DOCTOR GUTHRIE was born in Brimfield, Massachusetts. He studied medicine with his father and at the Columbia College medical school in New York and the University of Pennsylvania in Philadelphia. After a short time in Sherburne, New York, where his grandfather resided and where he married Sybil Sexton, he moved on to Sackett's Harbor, New York, settling in what was virtually a wilderness. As pioneer, he cleared the land, constructed a house, raised crops, practiced medicine, and became a practical chemist, building a factory to supply the developing countryside of northern New York with alcohol, vinegar and other needed substances, and the country as a whole with his priming powder invention which did away with the flash-in-the-pan type of powder and the old-fashioned flint-lock musket. He also developed potassium chlorate and mercury fulminate explosives and numerous other varieties of powder. Purified oil of turpentine and glucose syrup were other products. Another of his triumphs was the rapid conversion of potato starch into molasses. But the crowning triumph was the discovery of chloroform, this achievement in 1831 antedating its production, independently, by Liebig in Germany and Soubeiran in France.

Guthrie's experimental laboratory was near his house. His powder mill was about a mile away. His method of manufacturing chloroform was substantially that of today —by the action of chlorinated lime on alcohol. Soubeiran's method was identical with that of Guthrie. Liebig produced his chloroform by the action of potassium hydroxide on chloral.

No portrait of Guthrie exists, for the good reason that very numerous laboratory accidents had badly disfigured his features —and damaged his body and limbs in many places.

Guthrie practiced medicine to the last, but with gradually diminishing activity.

The anesthetic properties of chloroform were discovered by Simpson in 1847, so that shortly before his death Guthrie became aware that the vapor of his "sweet whiskey" had "spread like a benediction over the earth." Thus this contribution met the needs of the Guthrie-Simpson world *opportunely,* just as penicillin has answered today's demands. That is its significance and that is Guthrie's claim to a high place in the Pantheon of Medicine.

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A.C.J.

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The Projected Army Medical Library Building

As the outbreak of the war hearings were in progress before a Committee in Congress, advocating a new Army Medical Library building to be erected at a cost not exceeding $4,750,000. These hearings were terminated during the war. On account of increased costs and modernization and expansion of the original plans, Congress is now asked for $10,000,000. The Library has now been reorganized and it is impossible longer to carry on in the present building which was built in 1887. The need for the new building has never been disputed. A proper building must be provided which will enable the Library to furnish service to the medical profession throughout the country and to many parts of the world.

CONTEMPORARY PROGRESS

GYNECOLOGY

The Treatment of Primary Dysmenorrhea with Deproteinated Pancreatic Extract (Depropanex)

L. L. GROSSMAN (*American Journal of Obstetrics and Gynecology*, 50:411, Oct. 1945) presents a review of the literature showing that no therapeutic agent has been found that consistently gives favorable results in the treatment of dysmenorrhea. Recent laboratory and cilinical studies have indicated that dysmenorrhea occurs only when there are active uterine contractions that are of the spastic type. Hence it was decided to employ a non-toxic spasmolytic agent, depropanex (a deproteinated pancreatic extract), in the treatment of dysmenorrhea. This preparation has been employed in peripheral vascular disease and in urology to induce relaxation of spastic smooth muscle. Two groups of patients with dysmenorrhea were treated. Twenty-five patients in private practice were given a total of 63 treatments of 1.5 to 4 cc. of depropanex by intramuscular injection. Complete relief from dysmenorrhea was obtained in fifteen minutes to half an hour after 50 treatments (79.4 per cent); and partial relief after 11 treatments. Thirty-one patients working in an industrial plant were given 41 treatments with depropanex in the same dosage. Complete relief from dysmenorrhea followed 22, or 53.7 per cent, of these treatments; and partial relief followed 6, or 14.6 per cent, of the treatments. The disparity of results in the two groups is explained by some of the difficulties met with in the treatment of the industrial group. The results, as a whole, inidicate that depropanex is of definite value in the treatment of dysmenorrhea.

COMMENT

Dysmenorrhea remains the enigma of gynecology. Volumes have been written on its management and innumerable therapeutic agnts "invented" for its relief but like "ol' man river" dysmenorrhea "jes keeps rollin' along". Any therapeutic remedy, therefore, that will relieve even one-half the cases, is worthy of serious consideration. With a preparation known as depropanex (a deproteinated pancreatic extract) Dr. Grossman was able to obtain exceptional results—79.4 per cent in a private patient group and 53.7 per cent in an industrial group were completely relieved. We have had no personal experience with depropanex but will not hesitate to try it. It apparently is non-toxic. As we "grope" we may find a "cure"—even for all types of dysmenorrhea.

H.B.M.

The Value of the Vaginal Smear in the Diagnosis of Uterine Cancer; A Report of 1015 Cases

J. V. MEIGS and his associates (*Surgery, Gynecology and Obstetrics* 81:337-45, Oct. 1945) report the use of the vaginal smear method in 1015 patients. No evidence of cancer was found in 861 of these patients, and 317 were proved not to have cancer by biopsy or by histological examination of the uterus after hysterectomy. There were 48 patients clinically well after surgical treatment of uterine cancer and 89 clinically well after radiation therapy included in this negative group. The negative group also included patients who did not require operation because of lack of evidence of malignant disease. In this group there were 25 in which a positive diagnosis of uterine cancer was made by vaginal smear, but repeated biopsies failed to show evidence of carcinoma. This gives an error of 29 per cent for "negative called positive." There were 154 cases in which cancer was proved by microscopical examination, including 39 endometrial and 109 cervical cancers, and 6 vaginal carcinomas. There were 16 of these cases in which the vaginal smear was negative for cancer. On review of the vaginal smears, cancer cells were found in 7 cases, which had been missed on the original examination because every field was not examined. Of the 9 cases in which cancer cells could not be found in the

vaginal smears, 6 were cases of endometrial cancer. This indicates that the vaginal smear method is definitely less accurate for endometrial than for cervical cancer. The appearance of the cancer cells in the vaginal smear of different types of cancer is described. The malignant cells in the vaginal smear show more variation than in the histological section of the tumor from the same case. Certain cells, probably histiocytes, that show some resemblance to malignant cells are also described; it is probably the presence of these cells that led to a false positive diagnosis ("negative called positive") in certain cases. Eight illustrative cases are reported in which the diagnosis of cancer was made primarily by vaginal smear; 5 of these were cervical cancer, and 3 of these represented carcinoma *in situ* of the cervix. The authors conclude that the vaginal smear is of definite aid in the diagnosis of cancer of the uterus; a negative smear does not exclude cancer, but a positive smear indicates that biopsy and further clinical observation are necessary.

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COMMENT

There can be no arguments against the employment of any reasonable procedure in the diagnosis of cancer of the uterus or other pelvic organs. Early diagnosis is still the "keynote" in the cure of cancer. The vaginal smear, as is now well known, is a distinct advance in early diagnosis in not a few cases. Negative smears do not exclude cancer; but positive smears indicate that further study is obligatory. Every "tumor" and/or gynecological clinic should employ the "vaginal smear method" as another means of detecting early cancer. Remember! the earlier the diagnosis, the more certain the cure. ***H.B.M.***

Androgen Therapy of Menopausal Symptoms in Cancer Patients

S. B. GUSBERG (*American Journal of Obstetrics and Gynecology* 50: 502, Nov. 1945) has employed androgen therapy in a small group of patients with menopausal symptoms who either had been treated for some form of cancer of the reproductive organs or had developed uterine bleeding under estrogen therapy. The author is of the opinion that the percentage of women who require endocrine treatment for menopausal symptoms is small, and for most of those who do require such treatment, stilbestrol in small doses is both safe and effective. Androgen therapy is indicated in only the small group noted above, and has been employed in 24 cases. In most of these cases methyl testosterone was given by mouth, 20 mg. daily for four weeks, then 18 mg. daily for two weeks, usually allowing several intervals of one week without treatment during the course. In some cases treated early in the series testosterone propionate was given by injection. Definite relief of the vasomotor symptoms of the menopause was obtained in 23 of the 24 patients treated; in the case in which treatment was ineffective there was a "large psychoneurotic element." The best results were obtained in 16 patients whose menopause was recent; less complete relief was obtained in the late

menopause. One patient showed "possible slight hirsutism;" this patient had been given both oral and parenteral treatment; there were no other undesirable effects of the therapy. Twelve patients had had previous stilbestrol therapy and 10 of these showed a more satisfactory response to androgen therapy.

COMMENT

Your commentator heartily agrees that many menopausal patients do not require endocrine therapy. "Just another therapeutic racket" has been very aptly applied to that school of practice that gives endocrines — female and/or male—for almost every illness known to the gynecologist. On the other hand, there are a considerable number of menopause cases in which the endocrines are of distinct help. Not a few of these are certainly relieved by androgen therapy. As Dr. Gusberg points out, there is a small group of patients who have been treated for cancer of some part of the reproductive system or who develop uterine bleeding under estrogen therapy who respond very nicely to the usual androgen preparations. The indiscriminate use of the endocrines—female or male—is something all physicians should guard against. The public is "getting wise" and the reaction on the profession of medicine generally is distinctly disturbing. Think it over!

H.B.M.

The Curability of Granulosa-Cell Tumors

G. E. SEEGAR JONES and R. W. TE LINDE (*American Journal of Obstetrics and Gynecology* 50:691, Dec. 1945) report 3 cases of granulosa-cell tumor of the ovary, in which the tumors were considered benign at the time of the original operation, although 2 of the patients showed excessive fluid in the abdomen. The tumors were well encapsulated and there was no evidence of metastases or implantation; but in one case there was rupture of a small cytic locule with escape of serous fluid, which might possibly have been a factor in dissemination. All 3 patients remained apparently well for a period of at least fifteen years, but all died of the disease, eighteen, twenty and twenty-one years respectively after the original operation. In one of the cases in which widespread metastases occurred a bilateral salpingo-oophorectomy and hysterectomy had been done at the original operation. In another case in which a unilateral salpingo-oophorectomy was done at the original operation, the second tumor was located in the retroperitoneal space on the opposite side, without involvement of the remaining pelvic organs. Such cases indicate that prognosis in individual cases of granulosa-cell tumor of the ovary is "most uncertain," irrespective of whether a readical operation is done or not. In all these cases the second tumor developed after the patient had passed the menopause, and at this time all showed abnormally high urinary estrogen values for postmenopausal women, and also showed clinical evidence of estrogenic activity at the time of recurrence of the tumor.

COMMENT

The curability of granulosa-cell tumors brings up a moot question among pathologists. Some authors believe all such tumors are malignant; while others believe that many are benign but may, under certain unknown conditions, become malignant. All admit that there must be further observation, investigation and study before any "standard" conclusions are arrived at. The authors report three cases which certainly illustrate the "uncertainty" in relation to this type of cell growth. Those who do gynecological surgery should "read up" granulosa-cell tumors—they are rare but very important.

H.B.M.

A Comparative Study of the Clinical Responses of Women with Hypofunctioning Ovaries to Two Methods of Combined Gonadotropic Therapy

C. D. DAVIS and E. C. HAMBLEN (*American Journal of Obstetrics and Gynecology*, 50:269, Sept. 1945) report a study of the results of two methods of gonadotropic therapy in 21 patients with ovarian hypofunction. Of the 21 patients, 9 showed deficient sexual maturation, 6 infrequent and/or scanty estrogenic bleeding, 5 prolonged and/or excessive estrogenic uterine bleeding, and 6 "presumed" ovarian sterility with bleeding from premature progestational endometrium. One method of therapy was the sequential and cyclic administration of equine and chorionic gonadotropins, the so-called one-two cyclic gonadotropic therapy, previously described by the authors; the other method employed

a mixture containing pituitary synergist and chorionic gonadotropin, given for twenty days from the fifth through the twenty-fourth day of the cycle. None of the 4 patients with deficient sexual maturation were benefited by either method of treatment. The patients with infrequent and/or scanty estrogenic bleeding and those with prolonged and/or excessive estrogenic bleeding responded to both methods of therapy, but there was a higher incidence of positive responses with the one-two cyclic gonadotropic therapy. Neither method of therapy resulted in pregnancy in the group of sterile patients with bleeding from immature progestational endometrium. On the basis of these findings the authors consider the one-two cyclic gonadotropic therapy superior to therapy with the mixture of pituitary synergist and chorionic gonadotropin in ovarian hypofunction, especially as the latter is associated with a higher incidence of untoward reactions.

OBSTETRICS

The Physick-Sellheim Principle of Extraperitoneal Cesarean Section

J. V. RICCI and J. P. MARR (*American Journal of Surgery,* 71:3, Jan. 1946) describe a technic of extraperitoneal cesarean section employed in most of the 175 cases reported. The first major step of this operation is the liberation of the anterior peritoneal fold from the upper surface and dome of the bladder. As the bladder is flattened and empty and its musculature relaxed under anesthesia, preliminary finger massage of the bladder is done to contract it, to loosen it from its fascial capsule, and to diminish the danger of injury. The second major step of the operation is the liberation of the posterior peritoneal fold from the posterior surface of the bladder and the lower uterine segment. The peritoneal and fascial relationships to the bladder and lower uterine segment and the various procedures in these two major steps of the operation are described in detail. When the entire lower segment is exposed, the midpoint of this segment is located and a transverse incision is made; sutures are placed in this incision as guides and for traction before the child is delivered. The placenta is delivered, preceded by the use of pituitrin and ergotrate. The margins of the incision are then brought into view by traction on the guide sutures, and repair is done with two layers of chromic No. 0 sutures; after the bladder is elevated to the correct position, the transversalis fascia is reunited by interrupted sutures. Sulfanilamide is sprinkled over the operative field and then a rubber tissue drain inserted. The 175 cases in which extraperitoneal cesarean section was employed included some surgically clean cases and a few in which the patient was not in labor, but many patients in this series had had a prolonged labor with ruptured membranes and were potentially or actually infected. There was one maternal death in the series, due to hemorrhage approximately 16 hours after operation. This patient was delivered in a small private institution without adequate postoperative supervision and no blood was available for transfusion. There were 6 cases of bladder injury successfully repaired at the time of the cesarean operation; and 2 other cases in which the bladder injury was not discovered at the time of operation but was successfully repaired later. There were 3 cases of phlebitis. The postoperative condition of the patients in this series was usually good; as a rule urine was voided without catheterization; abdominal distention and discomfort were absent or slight and temporary; fluids and food were usually taken a few hours after operation. There were 7 fetal deaths, including one monster with hydrocephalus.

COMMENT

That extraperitoneal cesarean section has a distinct place in obstetrics cannot be disputed. Many lives have been saved and much morbidity eliminated or greatly reduced by its employment. On the other hand, it seems to us, too many enthusiastic operators employ this technique when a simpler one would entirely suffice. "Practice makes perfect" is a good working axiom but suppose the "practice" is upon one's wife or daughter. Simple procedures, if not contraindicated, produce less mortality and morbidity. Your commentator, therefore, cannot wax too enthusiastic over the routine or nearly routine use of the extraperitoneal type of cesarean section. We

congratulate the authors on their very excellent results in the 175 cases making up this report. It would be indeed difficult to better them. Yes, we have done a goodly number of extraperitoneal cesarean sections and have no regrets—the Latzko in earlier years; the Waters more recently. Certainly every qualified obstetrician should be able to perform some type of extraperitoneal operation to be done only on reasonable indications. Alas! how much better the parturient and her baby would fare if the decision to perform cesarean was made before the extraperitoneal operation was indicated.

H.B.M.

Should We Change Our Present Standards of Infant Viability?

R. L. HAAS (*American Journal of Obstetrics and Gynecology* 50:406, Oct. 1945) presents a review of the literature on the survival of premature infants and finds 54 cases reported in which infants survived when the birth weight was less than 1000 grams (2 lbs. 3 ozs.). He reports 3 other cases in which the birth weights were 705 gm., 934 gm., and 830 gm., respectively. The oldest of these infants with the lowest birth weight is now over three years old, normal and active. In the case of these infants, it was found that the use of properly adjusted artificial feeding formulas gave good results, when breast milk was not obtainable. New developments in obstetrics have improved the survival rate of premature infants. Among these the author mentions particularly new and improved incubators and nursery equipment available to all; the use of caudal anesthesia in labor, which relaxes the structures around the birth canal and minimizes trauma to the fetal head; the knowledge of the Rh-factor which makes it possible to save premature infants with hemolytic anemia by proper transfusions. On the basis of these findings, the author suggests that 1000 grams (2 lbs. 3 ozs.) be used as a lower weight limit of viability for statistical purposes.

COMMENT

The question "should we change our present standards on inant viability?" has been up for consideration many times. It is, of course, very difficult to find the correct answer. There are a multitude of governing factors— ranging from heredity; to personality; to physical plant; including the skill of doctor and nurse in the management of the premature infant. Truly! a tremendous problem. However, as the author points out, new developments in obstetics, and we would add pediatrics too, have improved the survival rate of premature infants. This "team" has never worked together better and survival rates are higher than ever before. May we ask: Why lower the limit of viability?

H.B.M.

Diet Regulation and Controlled Weight in Pregnancy

W. J. DIECKMANN and his associates at the University of Chicago (*American Journal of Obstetrics and Gynecology*, 50:170, Dec. 1945) review the recent literature on the regulation of diet in pregnancy. They find that some of the conclusions as to the value of diet during pregnancy in decreasing the incidence of abortion, prematurity, fetal abnormalities, stillbirths and neonatal deaths appear to be at variance with clinical obstetrics and not supported by study of large series of cases. They are of the opinion that research projects in maternal nutrition should be carried out in many clinics so that a sufficient material will be available. A diet containing adequate amounts of essential foods with special attention to protein, vitamins and minerals is of importance to the pregnant woman in preventing anemia and increasing resistance to infection. Overfeeding, however, should be avoided in pregnancy and the gain in weight controlled, as the incidence of toxemia is higher in pregnant women who gain more than 13 kilograms, especially if the rate of gain is over 0.6 kilograms per week. In the antenatal clinic, therefore, the authors have planned the diet during pregnancy to supply the essential foods, without increasing the caloric intake above 1800 calories daily. If the patient's weight is "ideal" before pregnancy, the maximum gain during pregnancy should be 7 to 8 kilograms. Suitable dietary instructions are given each patient attending the clinic. A basic diet form has been prepared on which is noted the value and use of each food for a daily intake of 1800 calories; appropriate adaptations of this basic plan are made according to variations in size, age,

activity, and food habits of the patient and the cost of the food. In the time of food shortages and ration restrictions, instructions concerning "food alternates" have also been given, particularly in regard to protein-containing foods. The restrictions on fats have been found to be advantageous rather than disadvantageous because of the need for caloric limitation. A correlation of the dietary outlined with the laboratory and clinical findings in a group of these patients is planned to determine the relation between nutrition and the incidence of toxemia, anemia, prematurity and other factors.

Comment

Diet in pregnancy is foremost in importance in prenatal care. There is no question but that with proper diet, given a well woman to begin with, most of the ills during pregnancy can be minimized or prevented. This is particularly true of the toxemias of pregnancy. We do not see eclampsia where adequate prenatal care, which certainly includes diet, is given throughout pregnancy. Most medical students graduate nowadays without having seen an eclamptic convulsion. Furthermore, a diet containing adequate amounts of the essential foods is most important in preventing anemia and in increasing resistance to infection. On the other hand, overfeeding is bad because it causes too much gain in weight. No woman should be permitted to gain more than 20 to 25 pounds during her pregnancy. This is an absolute rule in our practice. In consultation practice we have found that the "troubles we see" are in those patients who have been allowed to gain more than 25—and up to 60 pounds. Diet in relation to abortion, prematurity, fetal abnormalities, stillbirths and neonatal deaths has not been proven beneficial nor prophylactic. Remember! diet can be of inestimable value in one's success as an obstetrician. Try it out if you are skeptical.

H.B.M.

Nausea of Pregnancy Treated by Forced Hydration

W. C. ELLER and J. H. RANDALL (*American Journal of Obstetrics and Gynecology* 50:518, Nov. 1945) report 68 cases of nausea and/or vomiting of early pregnancy treated by forced hydration with resulting diuresis. This treatment was employed on the theory that the nausea of pregnancy is the result of the high concentration of chorionic gonadotropin during the first trimester and that increased elimination by the kidneys would lower this concentration below a theoretical "nausea threshold." A definite schedule of treatment was given each patient. As the nausea of pregnancy is usually worse in the morning ("morning sickness"), the schedule includes a "fairly dry breakfast" of toast and jelly and dry cereal with a small amount of milk. There is no other limitation of the diet. Four glasses of water are to be taken between breakfast and lunch; 5 glasses between lunch and supper; and 6 glasses between supper and bedtime. The patient is instructed to reverse this schedule if she is nauseated in the evening rather than in the morning. This schedule makes it necessary for the patient to get up in the night to urinate, and she is instructed to drink a glass of water each time she gets up. If the patient vomits any of the water when treatment is first begun, she is instructed to take another glass of water immediately and to count only the glasses retained. The urine becomes almost colorless in a day or so if sufficient water is being taken. In some cases, the patient finds that she can retain hot or salt water better than cold water. The theory of the treatment is also explained to the patient. Results were considered very satisfactory if complete relief was obtained in 4 days or less when the patient was still less than three and one-half months pregnant; and satisfactory if complete relief was obtained in ten days or less in patients less than three and one-half months pregnant. Very satisfactory results were obtained in 32 patients (47 per cent) and satisfactory results in 10 patients (14.7 per cent); in the latter group relief was obtained within seven days in all but one case. In 16 other patients complete relief was obtained, but in more than ten days or when the patient was over three and one-half months pregnant. There were 10 patients with whom the treatment failed, but in 6 of these treatment was not adequately carried out. The authors conclude that this method of treatment can be recommended for the nausea of early pregnancy for its "simplicity, economy, and effectiveness."

COMMENT

The nausea and/or vomiting of early pregnancy is always a complaint "to listen to" but often very little help can be given. Occasionally, yet, any of the "400 suggestions" may give relief but "by and large" the lady still has nausea, if not vomiting. Any simple remedy, therefore, that the patient can carry out at home is worthy of serious consideration. The authors have recommended such a treatment and have employed it with considerable success. We have not tried this routine but certainly can see no contraindications to its use, except perhaps in the occasional severe cardiorenal case. Read this article carefully and try it on your next case. You may be surprised to find it works.

H.B.M.

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PULMONARY TUBERCULOSIS

—Concluded from page 98

Fig. 6. Stephen B. 2/3/44

This film was taken after the lung had been allowed to re-expand. We now see a fibrocaseous cavitary lesion involving the upper third of the left pulmonary area. Two distinct cavities can be seen in the left upper lobe.

Fig. 7. Stephen B. 4/12/45

Shows the appearance of the lesion fourteen months after the institution of pneumoperitoneum as a procedure supplementary to phrenic neurectomy. No evidence of cavitation can now be observed. The left hemidiaphragm is markedly elevated as compared to the right. Marked fibrosis of the tuberculous process has taken place.

7300 Germantown Avenue

(To be continued)

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IDEALS OF PEDAGOGY

—Concluded from page 135

an active, intimate association of our powers to prevent the great ravaging disease of war, and to cure the international ills from which nations suffer. To attempt to cure those ills by war is a prescription as futile, as senseless and as fatal, as bloodletting ever was.

The parallel is so plain, I think, that I need not trace it further.

It is your function to lift the weight of disease from the shoulders of men, by every means you know, with every aid you can enlist. This can be the meaning of democracy to you. In this direction leads the American way of life.

✚

American Public Health Association Meeting

The Executive Board of the American Public Health Association announces the 74th Annual Meeting of the Association to be held in Cleveland, Ohio, the week of November 11, 1946.

This will be the first full-scale convention of this professional society of public health workers since 1942. In 1943 and 1944, streamlined wartime congresses on public health were held and in 1945, for the first time in its history, the organization held an Annual Meeting.

An attendance of 4,000 is anticipated, representing every state in the United States, Canada, South America and many countries outside this hemisphere.

Dr. Harold J. Knapp, Cleveland's Health Commissioner, has been appointed the Chairman of the Local Committee.

Hearing Aids

One out of every 300 adults in the United States now wears a hearing aid. Increased use of hearing aids is not the result of mounting deafness, but comes from a growing desire of deafened persons to overcome their handicap.

Medical BOOK NEWS

Edited by
ALFRED E. SHIPLEY, M.D., Dr. P.H.
All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn 16, N. Y.

Classical Quotations

● **I have observed, and in part photographed, many shadow-pictures of this kind, the production of which has a particular charm. I possess, for instance . . . the shadow of the bones of the hand; the shadow of a covered wire wrapped on a wooden spool; of a set of weights enclosed in a box; of a compass in which the magnetic needle is entirely enclosed by metal; of a piece of metal whose lack of homogeneity becomes noticeable by means of the x-rays, etc.**

WILHELM CONRAD ROENTGEN
***Eine Neue Art von Strahlen.* Wurzburg, 1895.**

Mayo Clinic Papers

Collected Papers of the Mayo Clinic and the Mayo Foundation. Edited by Richard M. Hewitt, M.D., and others. Vol. 35, 1943. Philadelphia, W. B. Saunders Co., [c. 1944]. 875 pages, illustrated. 8vo. Cloth, $11.00.

A REVIEW of such a collection of papers must be general in nature with emphasis on the wisdom of the editors in making their selections, on the excellence of the printing, and on the importance of the information not only to the specialist and to the investigator but to the general practitioner. We like to quote from the Foreword that generous contributions to the art and science of medicine come from this clinic and Foundation—"The papers surveyed for inclusion in this volume were received from December 1, 1942 to November 30, 1943. There came under consideration 475 papers. Of these, sixty-five appear in full, fifty-one by abridgment, forty-nine by abstract and 310 by title." Only the titles of papers printed in the *Medical* or *Surgical Clinics of North America* are given.

The papers are arranged, as in previous Collections, under general anatomical headings, with about 100 pages devoted to Miscellaneous topics. At the end of each chapter or anatomical division is a list of papers by title and reference only. There is an Index of Contributors and an informative Index of Subjects.

JOSEPH RAPHAEL

Community Health Care

Public Medical Care, Principles and Problems. By Franz Goldman, M.D. New York, Columbia University Press, [c. 1945]. 8vo. 266 pages. Cloth, $2.75.

THE author says: "Even if thoroughly adequate programs of voluntary health insurance were to exist throughout the country, the contributions necessary to make them self-sustaining would be too high for a large proportion of the population." It would seem that here is the really great problem: to provide the best medical care for all the people at a cost which all the people can afford to pay. The essayist believes the solution to lie in the domain of compulsory insurance as a part of the general extension of social insurance and as the expression of progress and forward thinking in social philosophy. It is argued that the "right to life" is, in reality, the "right to health."

However much one may disagree with the plans projected and whereas we must insist that the method of medical practice must remain unbossed and free from governmental control, even though the method of payment for medical practice may be modified, yet "medical care in its widest sense for every individual is an essential condition of maximum efficiency and happiness in a civilized community."

Public Medical Care is recommended

as "must" reading for all those sincerely interested in today's problems of medical care.

BENJAMIN M. BERNSTEIN

Helping the Alcoholic

A Guide on Alcoholism for Social Workers. By Robert V. Seliger, M.D., in collaboration with Victoria Cranford. Baltimore, Alcholism Publications. [c. 1945]. 8vo. 94 pages. Paper.

IN this small book the author has directed an inquiry into the causes of abnormal drinking in a unique way. He addresses himself to the alcoholic and asks for his cooperation by reasoning with him about his habit and behavior. Although the author makes an attempt to fathom the causes of alcoholism, it is not altogether clear whether he arrives at his objective or merely succeeds in making the drinker aware of his habit by confronting him with his character defect which caused him to become a habitué. The author enlists the assistance of social workers in the job of rehabilitating the drinker by familiarizing the social worker with the entire social problem involved as well as with the way to deal with the individual and his environment.

According to the author this is a workable method, which gives good results. The book, therefore, deserves popular attention and is recommended to all who are interested in the subject.

SIMON ROTHENBERG

BOOKS RECEIVED

for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notices will be promptly published shortly after acknowledgment of receipt has been made in this column.

Atlas of Surgical Approaches to Bones and Joints. By Toufick Nicola, M.D. New York, Macmillan Co., [c. 1945]. 4to. 218 pages, illustrated. Cloth, $5.00.

Diseases of the Nose, Throat, and Ear. Including Bronchoscopy and Esophagoscopy. Edited by Chevalier Jackson, M.D. & Chevalier L. Jackson, M.D. With the collaboration of 64 outstanding authorities. Philadelphia, W. B. Saunders Co., [c. 1945]. 4to. 844 pages, illustrated. Cloth, $10.00.

Mitchell-Nelson Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D. With the collaboration of 49 contributors. 4th Edition. Philadelphia, W. B Saunders Co., [c. 1945]. 4to. 1350 pages, illustrated. Cloth, $10.00.

Informacion Sobre la Lucha Antituberculosa en Espana y Memoria. By Dr. B. Benítez Franco. Madrid, Patronato Nacional Antituberculoso, [c. 1945]. 4to. 366 pages, illustrated.

Men Without Guns. By DeWitt Mackenzie. Descriptive Captions by Major Clarence Worden (Med. Dept., U.S.A.). Philadelphia, The Blakiston Co., [c. 1945]. Folio. 47 pages, and 137 plates from the Abbott Collection of paintings. Cloth, $5.00.

The Romance of Human Architecture. By Maurice Chideckel, M.D. Boston, Bruce Humphries, [c. 1945]. 8vo. 107 pages. Cloth, $2.00.

The Effect of Smallpox on the Destiny of the Amerindian. By E. Wagner Stearn, Ph.D. & Allen E. Stearn, Ph.D. Boston, Bruce Humphries, [c. 1945]. 8vo. 153 pages. Cloth, $2.50.

A Future for Preventive Medicine. By Edward J. Stieglitz, M.D. New York, Commonwealth Fund, [c. 1945]. 8vo. 77 pages. Cloth, $1.00.

Human Biochemistry. By Israel S. Kleiner, Ph.D. St Louis, C. V. Mosby Co., [c. 1945]. 8vo. 573 pages, illustrated. Cloth, $6.00.

Man Against Pain. The Epic of Anesthesia. By Howard Riley Raper. New York, Prentice-Hall, [c. 1945]. 8vo. 337 pages, illustrated. Cloth, $3.50.

Personality Factors in Counseling. By Charles A. Curran, Ph.D. New York, Grune & Stratton, [c. 1945]. 8vo. 287 pages, illustrated. Cloth, $4.00.

Local Health Units for the Nation. A Report. By Haven Emerson, M.D. & Martha Luginbuhl. New York, Commonwealth Fund, [c. 1945]. 4to. 333 pages, illustrated. Paper, $1.25.

Individual Gymnastics. A Handbook of Corrective and Remedial Gymnastics. By Lillian Curtis Drew. Revised and Edited by Hazel L. Kinzly. 5th Edition. Philadelphia, Lea & Febiger, [c. 1945]. 8vo. Cloth, $2.75.

The Falling Sickness. A History of Epilepsy from the Greeks to the Beginnings of Modern Neurology. By Owsei Temkin, M.D. Baltimore, Johns Hopkins Press, [c. 1945]. 4to. 380 pages, illustrated. Cloth, $4.00.

Mental Disorders in Later Life. Edited by Oscar J. Kaplan. Stanford University, Calif., Stanford University Press, [c. 1945]. 8vo. 436 pages, illustrated. Cloth, $5.00.

Pathology in Surgery. By Nathan Chandler Foot Philadelphia, J. B. Lippincott Co., [c. 1945]. 4to. 511 pages, illustrated. Cloth, $10.00.

Science and Scientists in the Netherlands Indies. Edited by Pieter Honig & Frans Verdoorn. New York, Board for the Netherlands Indies, Surinam & Curacao, [1945]. 4to. 491 pages, illustrated. Cloth, $4.00.

The Person in the Body. An Introduction to Psychosomatic Medicine. By Leland E. Hinsie, M.D. New York, W. W. Norton & Co., [c. 1945]. 8vo. 263 pages. Cloth, $2.75.

Injury and Death of Bacteria by Chemical Agents. By Otto Rahn. Normandy, Missouri, Biodynamica, [c. 1945]. 8vo. 183 pages, illustrated. Cloth, $3.60.